STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 00 B. WING	06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 29, 30, 31, June 1, 4, and 5, 2012 Facility number: 005954 Provider number: 155767 AIM number: N/A Survey team: Barbara Gray RN TC Sharon Lasher RN Leslie Parrett RN (May 31, June 1, 4, and 5, 2012) Angel Tomlinson RN Census bed type: SNF: 50 Residential: 31 Total: 81 Census payor type: Medicare: 24 Other: 57 Total: 81 Residential sample: 7 This deficiency reflects state findings cited in accordance with 410 IAC 16.2.	F0000	This Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this faciltiy.We respectfully request paper compliance for this Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on June 13, 2012 by Bev Faulkner, RN			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to thoroughly assess and document the root cause of falls, initiate appropriate fall interventions, or ensure interventions were followed for 2 of 4 residents reviewed of 11 who met the criteria for accidents. (#31 and #12) Findings include: 1.) On 5/29/12 at 4:00 P.M., Resident #31 was observed seated in her wheelchair in her bedroom alone. She had a thick pressure relieving cushion on her wheelchair seat. She had an abrasion on her right forehead, a bruise under her left and right eye, and her right forearm at the wrist. She indicated she had fallen but was unable to provide details of the fall. She was unable to respond appropriately to questions asked. Resident #31's record was reviewed on 5/31/12 at 10:35 A.M. Diagnosis included but were not limited to diabetes, hypertension, osteoporosis,	F0323	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Residents #12 & #31's fall care plans and interventions were reviewed and updated during survey to determine appropriate interventions are in place and communicated properly on the CNA assignment sheets. Additionally, we have implemented a system where the therapy department will review the CNA assignment sheets to determine proper transfer requirements are recorded and communicated to nursing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents identified as fall risk's care plans and interventions will be reviewed to determine appropriate interventions are in place and communicated properly on the CNA assignment sheets. Additionally, the therapy department is now reviewing the CNA assignment sheets to determine proper transfer requirements are recorded and	07/05/2012

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	and dementia. Resident #31's admission Minimum Data Set assessment, dated 2/25/12, indicated Resident #31 required extensive assistance of 2 persons for bed mobility and transfers, she did not walk, and she had no history of falls. An Admission Resident Conference note for Resident #31, dated 3/2/12, indicated Resident #31 required 2 person assistance for transfer due to balance problems. An Occupational Therapy Progress Report for Resident #31 during the treatment period from 3/16/12 until 3/20/12, indicated Resident #31 was referred to skilled therapy for transfers, mobility, and activities of daily living. She required maximum assistance of 1 person and moderate assistance of 1 person for transfers. An interview with Occupational Therapist/Physical Therapist (OT/PT) Program Director on 6/4/12 at 2:24 P.M., indicated for the time period from 3/16/12 to 3/20/12, Resident #31 required 2 person assistance for transfers. She indicated Resident #31 required a maximum assist of 1 person and a moderate assistance of		communicated to nursing. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Director of Health Services and/or designee will review and provide a copy of the Falls Interventions (see Exhibit A) for all nurses. The InterDisciplinary Team will review the root cause of each fall to determine the appropriate root cause is identified and appropriate interventions documented and communicated to nursing staff. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:The InterDiscipilinary Team (IDT) will review all of the initiated Falls Circumstance forms in clinical meetings held five days per week. The IDT review is to ensure a thorough assessment and investigation is completed, identifying the root cause of the fall and that appropriate interventions were initiated. The CNA assignment sheets will then be updated to reflect fall interventions. The Director of Health Services or designee will audit five residents per week for four weeks, then monthly for 6 months to ensure fall interventions are in place and appropriate per resident's plan of care. The results of the audits will be presented to the Quality Assurance Committee monthly for further recommendations.	

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	another person. She indicated that on 3/23/12, Resident #31 became a maximum assistance to dependent, meaning Resident #31 would not be able to assist at all. A Fall Circumstance Assessment, and Intervention form for Resident #31 indicated the following: Resident #31 had an unwitnessed fall on 3/11/12 at 7:45 P.M., in the common area by the TV. She was in her wheelchair and staff were unsure how she got on the floor. Resident #31 suffered a bruise to her right wrist. The prevention update indicated a bed and chair alarm were added to her fall interventions. The root cause indicated Resident #31 had slid out of her wheelchair. A Fall Circumstance Assessment, and Intervention form for Resident #31 indicated the following: Resident #31 was assisted to the floor in her bedroom, next to her bed by CNA #2 on 3/21/12 at 6:00 A.M. Resident #31 suffered right knee edema and an abrasion to the top of her right foot and top of her right great toe. The prevention update indicated "teach wheelchair safety." The root cause indicated Resident #31 had slid out of her wheelchair related to a weakened state.			

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An interview with the Director of Nursing (DoN) on 6/1/12 at 11:58 A.M., indicated on 3/21/12 at 6:00 A.M., CNA #2 was assisting Resident #31 from her bed to her wheelchair and Resident #31's legs gave out and CNA #2 lowered Resident #31 to the floor. The DoN indicated she was unsure if CNA #2 utilized a gait belt for the transfer. The DoN was unable to provide inservice documentation on wheelchair safety. The DoN indicated she believed an inservice on wheelchair safety had not been provided to staff after the fall because the staff stopped getting Resident #31 out of bed due to the physician believed the resident was going to pass. The DoN indicated Resident #31 had a decline in her medical condition at that time and then her medical condition improved. After Resident #31's medical condition improved, staff began using a Hoyer Lift for transfers.

A Fall Circumstance Assessment and Intervention form for Resident #31 indicated the following: Resident #31 had an unwitnessed fall in the hallway beside her bedroom on 5/14/12 at 7:15 P.M. A Hoyer Lift was in front of Resident #31 and staff were unsure if Resident #31 had attempted to stand.

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	Staff were unable to determine how Resident #31 got on the floor from her wheelchair. Resident #31 suffered a skin tear to her right temporal area and her right leg. The prevention update indicated Resident #31 would not be left alone in her bedroom in her wheelchair and could be placed in her recliner chair. The Hoyer Lift would not be left in Resident #31's bedroom when it was not in use. The root cause indicated staff left Resident #31 alone in her bedroom in her wheelchair, with a Hoyer Lift in front of her. An interview with the DoN on 6/1/12 at 11:58 A.M., indicated after her investigation of Resident #31's fall on 5/14/12 at 7:15 P.M., it was determined Resident #31 was not in her bedroom but in the hallway with a Hoyer Lift in front of her. It was determined Resident #31 needed to be in eyesight of staff when she was in her wheelchair and not left alone in her wheelchair in her bedroom. A Fall Circumstance Assessment, and Intervention form for Resident #31 indicated the following: Resident #31 had a witnessed fall on the Browning Boulevard hallway on 5/22/12 at 1:30 P.M. Resident #31 was leaning forward to talk with			

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	another resident. Resident #31 suffered an abrasion to her right forehead and a skin tear to her right hand. The prevention update indicated a wedge cushion and Dycem were added to her fall interventions. The root cause indicated Resident #31 was leaning forward in her chair, talking with another resident. A Fall Care Plan for Resident #31 dated 3/3/12, indicated the following: Problem-At risk for fall/injury. Goals-The resident would have a reduced risk for fall related injury by utilizing fall precautions. Interventions-3/11/12- A bed and chair alarm were placed. 5/14/12- The resident would not be left alone in her room while up in her wheelchair. 5/22/12- A wedge cushion and Dycem were placed in the resident's wheelchair. An interview with the DoN on 6/1/12 at 11:58 A.M., indicated Resident #31's fall care plan did not include Resident #31's needed to be in eyesight of staff when she was in her wheelchair and a Hoyer Lift needed to be utilized for all transfers, and it should.			

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	2.) Review of Resident # 12's record on 6/1/12 at 10:00 a.m., indicated a document titled "Fall Circumstance, Assessment and Investigation," dated 1/22/12 at 2:15 p.m. "Location of fall: dayroom-200 hall... Injury location: none ... Activity at time of fall: sitting in wheelchair-slid out of chair... Personal inspection: none... Prevention Update: (new interventions) other: Dycem in wheelchair... Root cause: slid out of chair." Clinically at risk notes on 1/25/12 indicated Current status:... "Bed/chair alarms due to decreased safety awareness. 1/2 rails for positioning. Dycem added to wheelchair on 1/22/12, for prevention of slipping out of wheelchair..." Clinically at risk notes indicated on 2/1/12 weekly follow up: "continues to slide in wheelchair, needs repositioned per staff, Dycem in wheelchair." Review of a "Fall Circumstance Assessment and Intervention," dated 3/26/12 at 7:15 p.m., indicated "Location of fall: in 200 hall... Injury location: forehead... Activity at time of fall: transferring self... Personal inspection: Dycem in wheelchair with			

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	cushion and chair alarm in place... Other comments: alarm in use and functioning... Prevention Update: (new interventions)... diversion activities, Resident to be put into stationary chair or bed between meals... Root cause: Resident slid out of chair and forehead hit side of table." Review of a "Change in Condition Form," dated 3/26/12, indicated "Other: fall at 7:15 p.m. Pt. found on floor, hit forehead, 4 x 3 splotchy bruise noted, denies pain, will continue to monitor neuro's. MD and family notified." Clinically at Risk Monitoring Sheet, dated 4/11/12, indicated "weekly follow up: Intervention Update: wheelchair seat tilt added - no further incidents noted." No documentation as to why seat tilt was added to interventions. Residents record indicated a "Fall Circumstance, Assessment and Investigation" indicated on 5/23/12 at 6:45 p.m. "Location of fall: room... Injury location: none... Activity at time of fall: slipped... Personal inspection: cushion in wheelchair slid out with Resident... Other comments: Resident's cushion slid and Resident			

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	was sitting on foot pedals when found... Prevention Update: (new interventions)... wedge cushion, glasses in place, ensure wheelchair brakes are locked, bed and chair alarms, bed in low position, Dycem to wheelchair (wrote note to PT)... Root cause: Resident slid out of wheelchair." Falls care plan, dated 7/18/11, indicated "Problem: At risk for fall/injury. History of falls and potential for falls related to Alzheimer's/dementia. Goals: Resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions... dated 1/22/12 Dycem in wheelchair, 3/28/12 to be in bed or recliner between meals, 4/10/12 wheelchair seat tilt." Interview with DON on 6/1/12 at 11:35 a.m., indicated "I'm not sure why they did the seat tilt in April, she may have been sliding out, I really don't know." On 6/1/12 at 12:10 p.m., an interview with Occupational Therapy/Physical Therapy(OT/PT) Program Director indicated for Resident #12 "the interventions that are in place were not placed by OT/PT they must have been done as a nursing measure. No, we have not received a note from			

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	nursing related to Resident needing screened, but I will get an order from the MD to screen her for services." On 6/1/12 at 2:30 p.m., observation of Resident #12 sitting in a recliner in the lounge area. Resident was observed to be sitting slouched down in the recliner. The chair alarm was in place and functioning. Interview with LPN #3 on 6/4/12 at 2:00 p.m., indicated the wheelchair seat tilt was initiated on 4/11/12 related to "Resident was sliding out of her wheelchair." During observation of Resident #12 on 6/4/12 at 2:20 p.m., the resident was sitting slouched down in her wheelchair with a wedge cushion in place. Staff repositioned the resident to an upright position. On 6/4/12 at 2:30 p.m., observed Resident #12 sitting slouched down in her wheelchair. Interview with LPN #3 at that time indicated the resident would not sit in an upright position as the slouched position was her preference. Review of a document titled "Falls Management Program Guidelines" provided by the Director of Nursing on			

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	6/4/12 at 2 p.m., indicated "Purpose: Trilogy Health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury..." "Procedure: 1. the fall risk assessment is included as part of the Admission and Monthly Nursing Assessments and Review and Circumstance forms: a. Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. b. Care plan interventions should be implemented that address the resident's risk factors..." "3. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form." The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and			

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	appropriateness of the interventions. 4. An "Accident and Incident Report" should be completed at the time of the incident..." "7. The nursing assistant assignment sheet and resident care plan should be updated to reflect any new or change in interventions..." 3.1-45(a)(1) 3.1-45(a)(2)			